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WILLIAM T FUJIOKA
Chief Executive Officer

January 27, 2009

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Dear Supervisors:

APPROVAL OF RECOMMENDATIONS REGARDING THE USE OF $44.8 MILLION FOR THE PUBLIC PRIVATE PARTNERSHIP (PPP) PROGRAM (ALL DISTRICTS AFFECTED) (3 VOTES)

SUBJECT

This is a joint request, with the Interim Director of Health Services, to approve recommendations developed by the Public Private Partnership (PPP) Allocation Working Group, regarding the use of $44.8 million approved by your Board on October 7, 2008, for the PPP program, included in the attached report. The report also addresses your Board's request that the Chief Executive Officer (CEO) and Interim Director of Health Services determine what methodology can be used to enhance primary care efficiencies and how the specialty clinics will be handled in the augmentation of primary care services.

IT IS RECOMMENDED THAT YOUR BOARD:

Approve recommendations of the PPP Allocation Workgroup regarding the use of $44.8 million for the PPP program and instruct the Interim Director of Health Services to proceed with implementation of the proposals, including: 1) $4.8 million for capital projects/renovations, including equipment, to add or expand PPP clinic capacity in Service Planning Areas (SPAs) 1, 3, 6, 7 and 8; and 2) $40.0 million as follows: a) $1.5 million for the Encounter Summary Sheet project, to include all PPP Strategic Partners in all SPAs; b) $3.0 million for underserved geographic areas in SPAs 2, 4 and 5, for capital infrastructure, including equipment, and to fund new visits at PPP clinic sites; and c) up to $35.5 million over three years to SPAs 1, 3, 6, 7 and 8 for new patients at current or new PPP clinic sites.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

On October 7, 2008, your Board approved $44.8 million in one-time funds for the Department of Health Services' (DHS) PPP program and instructed this Office and the Interim Director of Health Services to reconvene the PPP Allocation Workgroup (Workgroup) to develop recommendations to be presented to the Board regarding the use of these funds.

Further, the Board requested the CEO and Interim Director of Health Services to determine what methodologies can be used to enhance primary care efficiencies and how specialty clinic services will be handled with this PPP augmentation.

The Workgroup conducted four public meetings, beginning with the first on November 19, 2008 and the fourth on January 16, 2009. During these meetings, the Workgroup received a considerable amount of input from participants, which the Workgroup considered in developing its recommendations regarding the use of the $44.8 million. The attached report includes the Workgroup recommendations, as well as additional responses and recommendations from CEO and DHS staff regarding the Board's directives.

The Workgroup members acknowledge that underserved areas can be found in all SPAs across Los Angeles County and that existing resources are not sufficient to meet the needs of all uninsured and underinsured County residents. Therefore, the $44.8 million approved by your Board, while one-time in nature, is essential to DHS efforts to support the PPP program.

The Workgroup recommendations offer proposals for the use of these one-time funds to: a) increase capacity in the underserved geographic areas of the County with the least amount of current resources, and b) best position the DHS/PPP program network to benefit from federal funds which could be available for health information technology and to maximize the County's participation in pending health care reforms.

In summary, the Workgroup recommended the following uses of the $44.8 million:

1. Utilize $4.8 million for capital projects/renovations, including equipment, to add/expand clinic capacity in SPAs 1, 3, 6, 7, and 8. Projects should already be designed/initiated with expected completion within two years.

2. Utilize $40.0 million as follows:

    a. $1.5 million for the Encounter Summary Sheet (ESS) project, to include all PPP Strategic Partners in all SPAs.

b. $3.0 million for underserved geographic areas in SPAs 2, 4 and 5, with funds to be used for capital infrastructure, including equipment, and/or to fund new visits at PPP clinic sites.

c. Up to $35.5 million over three years to SPAs 1, 3, 6, 7 and 8 for visits for new patients at current or new PPPs, including visits at sites chosen for the $4.8 million capital/infrastructure projects.

Included in the Workgroup recommendations is a proposal that additional funds from the $35.5 million may be made available for qualifying proposals in SPA 2 underserved geographic areas, as defined in the report, up to an amount that would maintain the SPA 2 proportional allocation of funds as determined by the 2008 Allocation Formula for the PPP program.

The attached report also provides information on DHS initiatives to improve access to, and manage demand for, specialty care services, in response to your Board's request. Among these initiatives is the DHS countywide deployment of the Referral Processing System (RPS), a web-based system that allows DHS and PPP program providers to make electronic referrals to DHS referral centers for specialty care. RPS has improved tracking and disposition of specialty care referrals, provides system wide information on the demand for specialty care, and improves the sharing of information between DHS and PPP providers and the return of the patient to their medical home.

Implementation of Strategic Plan Goals

The recommended actions support goal 7, Health and Mental Health, of the County's Strategic Plan.

FISCAL IMPACT/FINANCING

The $44.8 million related to the recommendations consists of $3.5 million in one-time Tobacco Settlement funds already in the DHS 2008-09 Final Budget and $41.3 million in the 2008-09 Provisional Financing Uses (PFU) budget for the DHS PPP program. DHS is not requesting that funds be moved from the PFU budget to the DHS budget at this time. DHS will submit separate requests to your Board for funding as the solicitation process and timeframe is developed. Therefore, there is no additional net County cost impact related to these actions.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

For purposes of the recommendations in the report, "underserved geographic areas" are federally designated Medically Underserved Areas (MUAs) in which residents have a shortage of health services or Medically Underserved Populations (MUPs), which are groups of persons who face economic, cultural or linguistic barriers to health care. The report includes a map attachment which shows the SPA boundaries and the MUA/Ps within the SPAs. In addition, areas which can clearly demonstrate eligibility for MUA or MUP designation can be considered eligible for this funding.

DHS will convene as needed meetings with the Community Clinics Association of Los Angeles County (CCALAC) leadership and its members to discuss issues related to implementation of these recommendations, including but not limited to actions that can be taken to maximize the use of funds available for proposals in underserved geographic areas where the lack of existing infrastructure is particularly severe. DHS may also use these meetings to discuss issues related to the development of performance measures and future proposals for special projects, as well as other process issues.

Further, DHS will discuss with CCALAC and its members other potential criteria in determining eligibility of "underserved geographic areas" for funds in categories above, including, among others, consideration of Health Resources and Services Administration Health Professional Shortage Area (HPSA) designation.

For planning purposes only, DHS has projected the distribution of the $38.5 million in recommended funding by SPAs based on their relative percentages from the 2008 Allocation Formula. The attached report includes a graph which reflects those planning projections.

In developing the potential distribution, DHS projected funding at a level which maintained SPA 8 at its current relative percentage level based on the 2008 Allocation Formula percentage. DHS then projected the balance of available funds for SPAs 1, 3, 6 and 7 in amounts which would increase their percent of funding to 71.5 percent of their 2008 Allocation Formula percentages. This methodology is similar to one included in the CCALAC written recommendations. For SPAs 2, 4 and 5, DHS allocated the $1.0 million a year based on their relative percentages from the 2008 Allocation Formula.

These planning estimates will change if additional funds are provided to qualifying SPA 2 projects to maintain SPA 2 at the 2008 Allocation Formula percentage. Actual funding percentages will depend on final approval of proposals submitted and qualifying for use of these funds.

CONTRACTING PROCESS

To implement the recommendations above, DHS is working in consultation with County Counsel to develop an expedited solicitation process which DHS is developing, in consultation with County Counsel. DHS will provide the Board, in regular reports beginning in March 2009, with information, including timelines, regarding the solicitation process, copies of the solicitation documents, and progress reports on selection of successful bids and awarding of funds to providers. Approval of funding agreements will be submitted for your Board's approval.

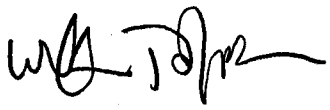
IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of the recommended uses of the $44.8 million will increase primary care services to residents in underserved areas of Los Angeles County.

CONCLUSION

The Public-Private Partnership program has been an effective relationship between the providers and Los Angeles County. The services provided by the PPPs are vital to our community and the investment of $44.8 million over the next three years will ensure the program continues and improves.

Respectfully submitted,



WILLIAM T FUJIOKA
Chief Executive Officer

WTF:SRH
SAS:bjs

Attachment

c: County Counsel
Interim Director, Department of Health Services

012709_HMHS_BLT_PPP Recommendations

Public-Private Partnership Program
Report and Recommendations
On Strategic Use of $44.8 Million
January 2009

On October 7, 2008, the Los Angeles County Board of Supervisors (Board) approved $44.8 million in one-time funds for the Department of Health Services' (DHS) Public Private Partnership (PPP) program. These funds consist of $3.5 million in one-time Tobacco Settlement funds already in the DHS 2008-09 Final Budget and $41.3 million in the Provisional Financing Uses budget for the DHS PPP program.

The Board also instructed the Chief Executive Officer (CEO) and the Interim Director of Health Services to reconvene the PPP Allocation Workgroup to develop recommendations to be presented to the Board regarding the use of these funds, including:

- How to most strategically use the $4.8 million in infrastructure dollars in "under-equity" SPAs;
- How to most strategically use the remaining $40.0 million (given the one-time nature of these funds) to address PPP inequity in "under-equity" SPAs over a three-year period, including replicating successful models and leveraging additional outside funding;
- Strategies for improving coordination of care – including the creation of medical homes, especially for frequent users of the emergency room services;
- Strategies on how the use of these funds can be implemented, monitored, and overseen to ensure accountability; and
- Direction that all areas of the County that are federally designated as underserved may be considered, along with "under-equity" SPAs, for funds earmarked for expanded PPP services.

Further, the Board requested the CEO and Interim Director of Health Services to determine what methodologies can be used to enhance primary care efficiencies and how specialty clinic services will be handled with this PPP augmentation.

The following report includes the recommendations of the PPP Allocation Workgroup regarding the use of the $44.8 million, as well as additional responses and recommendations from CEO and DHS staff regarding the Board's directives.

Background on PPP Program and April 2008 Report

Public-Private Partnership Program

The Public-Private Partnership Program is a collaborative effort between DHS and private, community-based providers (PPP providers) to provide quality health care services to the uninsured and underinsured. This program is administered by the DHS-Office of Ambulatory Care and currently includes a budget of over $54 million, which is used to reimburse PPP providers for primary care, dental and specialty services provided to uninsured patients.

Allocation Working Group and 2008 Allocation Methodology

On September 18, 2007, on a motion by Supervisors Molina and Yaroslavsky, the Board established a five-member PPP Program allocation formula working group (Workgroup) to provide recommendations on an equitable, countywide funding allocation methodology that will best meet the health care needs of the uninsured and underinsured residents of Los Angeles County.

As directed in the motion, the five-member Workgroup consisted of the Deputy Chief Executive Officer, Health and Mental Health Services, CEO, who served as Chair of the Workgroup; the DHS Director of Planning and Analysis; the DHS Interim Director of Ambulatory Care; and two representatives of the Community Clinics Association of Los Angeles County (CCALAC), neither of whom are current nor potential future PPP providers.

After a series of public meetings between December 20, 2007 and March 4, 2008, the Workgroup recommended the 2008 Allocation Formula, consisting 100 percent of "unmet need" for the distribution of PPP program funds. The unmet need calculation consisted of a) the number of uninsured (defined as individuals with incomes below 200 percent of the federal poverty level) and b) the utilization rates for uninsured patients based on data from the Los Angeles County Patient Assessment Survey, by Service Planning Areas (SPAs).

In applying the 2008 Allocation Formula, the Workgroup found that clinics in SPAs 2, 4 and 5 had aggregate funding levels above the percentages which would have been allocated to the SPAs using the 2008 Allocation Formula and clinics in SPAs 1, 3, 6, 7 and 8 had aggregate funding levels below the percentages which would have been allocated to those SPAs using the 2008 Allocation Formula. Therefore, due to concern regarding the potential impact on patients receiving services, the Workgroup recommended that the 2008 Allocation Formula not be used to redistribute the current PPP program funding between SPAs. However, in the future, the distribution of new unallocated funds would be based on the 2008 Allocation Formula.

Workgroup Recommendations on $44.8 Million

Background

Over the past several months, as directed by the Board, the Workgroup met in four public meetings to discuss areas under review in developing the recommendations included in this report and to obtain input from the stakeholders, including the CCALAC and its provider members. Participation at the meetings included staff from the Board offices and representatives of Service Employees International Union (SEIU) Local 721.

During these meetings, the Workgroup received a considerable amount of input from participants, including written recommendations from CCALAC and its members (Attachment I) and a summary document (Attachment II) and oral presentation from Bobbie Wunsch, Pacific Health Consulting Group, on recommendations from Key Informant Interviews, which were conducted under a project funded by the California Endowment. Both documents, as well as the stakeholder input from those present at the meetings, were considered by the Workgroup in developing the following recommendations.

Recommendations

It is important to point out, as in the April 2008 Workgroup report, that underserved areas can be found in all SPAs across Los Angeles County and that existing resources are not sufficient to meet the needs of all uninsured and underinsured County residents. Therefore, the Board-approved $44.8 million, while one-time in nature, is essential to the DHS efforts to support the PPP program.

The Workgroup recommendations below offer proposals for the use of these one-time funds to: a) increase capacity in the underserved geographic areas of the County with the least amount of current resources, so they can be prepared to take advantage of other available or new funding opportunities to sustain their operations, and b) best position the DHS/PPP program network to benefit from federal funds which could be available for health information technology and to maximize the County's participation in pending health care reforms.

For purposes of the recommendations below, "underserved geographic areas" are federally designated Medically Underserved Areas (MUAs) in which residents have a shortage of health services or Medically Underserved Populations (MUPs), which are groups of persons who face economic, cultural or linguistic barriers to health care. Attachment III is a map which shows the SPA boundaries and the MUA/Ps within the SPAs.

In addition, areas which can clearly demonstrate eligibility for MUA or MUP designation can be considered eligible for this funding. Further, DHS will discuss with CCALAC and its members potential other criteria in determining eligibility of "underserved geographic areas" for funds in categories below, including, among others, consideration of Health Resources and Services Administration Health Professional Shortage Area designation.

A) Use of $4.8 Million:

Workgroup Recommendation: Utilize funds for capital projects/renovations, including equipment, to add/expand clinic capacity in SPAs 1, 3, 6, 7, and 8. Projects should already be designed/initiated with expected completion within two years.

DHS and CEO propose the following:

a. Projects can be for: 1) (first priority) new sites of new or current PPP providers in underserved geographic areas of these SPAs; 2) (second priority) development of new sites in the SPAs; or 3) (third priority) expansions of existing sites.

   This prioritization was developed in order to first support development of new clinic sites in these SPAs to address the current lack of infrastructure, either in the underserved geographic areas or other close by areas within the SPA. However, on a case by case basis, DHS may determine that the needs of the area would be best and most expeditiously served by expansions of existing sites, as reflected in the CCALAC recommendations for use of the $4.8 million.

b. Projects may include a) new or expanded school-based health clinics that offer services to families and b) PPPs providing services at County directly operated sites.

   This language is intended to clarify that the DHS solicitation process will encourage proposals which seek to leverage other resources in meeting the need for additional infrastructure capacity in these areas.

c. A portion of the $40 million, as described below, should be set aside to fund visits at these new or expanded sites.

   The Workgroup felt it was essential that a portion of these funds be earmarked for new visits to be provided at the clinic sites/expansions funded by the $4.8 million in capital/infrastructure funds.

d. Recipients of funds must identify how County funds will leverage other funding streams and how the clinic will be sustainable after the three years of County funds are depleted.

At the public meetings, there was concern that the $4.8 million may not be enough to make a meaningful investment in infrastructure and a recommendation from some stakeholders that a portion of the $40.0 million should be added to this capital/infrastructure category. However, there were others who felt the amount for this category should be capped at $4.8 million. Ultimately, the Workgroup recommended that the amount be maintained at $4.8 million.

B) Use of $40.0 Million:

The following recommendations were developed to address Board instructions regarding equity issues and increasing primary care visits, as well as strategies for improving coordination of care; how use of funds can be implemented, monitored, and overseen to ensure accountability and encourage best practices; and consideration of all areas that are federally designated as underserved.

The Key Informant Interviews, and input from some stakeholders, included recommendations to use funds to implement new delivery models in order to improve coordination of care. While the Workgroup considered a recommendation to use a portion of the funds for special projects for new models of care, the members ultimately agreed with the general sense from the stakeholders that the best proposals would get funds out as quickly and with as much flexibility as possible.

Recommendations:

1. $1.5 million for Encounter Summary Sheet project, to include all PPP Strategic Partners in all SPAs (improves coordination of care).

   DHS has created an Encounter Summary Sheet (ESS), which is a patient history that is web-accessible and includes administrative and clinical information, such as diagnostics and frequency of visits, procedures performed, past and future appointments and a history of medications dispensed from DHS. Currently, the ESS displays information for services received at DHS facilities within 48 hours of the encounter. For the PPP clinic sites, the data feeding into the ESS is limited to claims data (diagnosis codes and visit date) that may be 45 to 90 days old. The ESS is currently only accessible to clinicians at select DHS facilities.

   Private grant funds have been secured to expand access to up to 16 PPP providers. The proposed $1.5 million would enable the project to expand the type and timeliness of clinical information reflected in the ESS and deliver the ESS to clinicians at all Strategic Partners in the PPP program.

   While the Workgroup acknowledged the importance of expanding the ESS project to all PPP providers, including Traditional Partners, the members believed that these funds, if approved for this project expansion, could be

used by CCALAC and DHS to leverage other private funds for inclusion of all community clinics, as well as funding for participation by private hospital emergency departments.

The Key Informant Interview responses reflected strong support for funding for investment in technology, in part to help ready the PPP provider network for health care reform and to access federal health information technology funds which may become available with the new federal Administration.

While the Workgroup considered whether to recommend the $1.5 million from the $4.8 million capital/infrastructure dollars above, the members ultimately agreed that the $4.8 million level of funding for SPAs 1, 3, 6, 7 and 8 should be maintained. This in part acknowledged the concern that $4.8 million may already be insufficient and, in addition, the fact that the ESS project expansion would benefit providers across all SPAs and not only the ones identified for allocation of the $4.8 million.

This recommendation provides a strategy for improving coordination of care in providing patient data, including frequent users of emergency room services.

2. $3.0 million for underserved geographic areas in SPAs 2, 4 and 5. Funds can be used for capital infrastructure, including equipment, and/or to fund new visits at PPP clinic sites.

While the Workgroup agreed that funding should be identified also to address the needs of underserved geographic areas in SPAs 2, 4 and 5, the difficulty was in identifying data that would assist the Workgroup members in recommending a specific funding amount from the $38.5 million remaining after adjusting for the proposed ESS project funds. Ultimately, the Workgroup's recommendation was based on unanimous agreement for $3.0 million, calculated by recommending $1.0 million per year for three years.

In addition, the Workgroup is recommending that additional funds from the remaining $35.5 million may be made available for qualifying proposals in SPA 2 underserved geographic areas up to an amount that would maintain the SPA 2 proportional allocation of funds as determined by the 2008 Allocation Formula.

Under the current distribution of PPP program funds, PPP clinics in SPA 2 receive almost 17.3 percent of PPP program funds, which is less than one percent above its 2008 Allocation Formula percentage of around 16.8 percent. Receiving only a portion of the $3.0 million would result in

SPA 2 falling below its 2008 Allocation Formula percentage, along with SPAs 1, 3, 6, 7 and 8.

3. Up to $35.5 million over three years to SPAs 1, 3, 6, 7 and 8 for visits for new (unique) patients at current or new PPPs in the following categories:

    i. Visits at sites chosen for the $4.8 million capital/infrastructure projects, including equipment.

    As noted above, the Workgroup felt it was essential that a portion of these funds be earmarked for new visits to be provided at the clinic sites/expansions funded by the $4.8 million in capital/infrastructure funds. This is first priority for these funds.

    ii. The remaining categories are not in priority order and will be subject to evaluation by DHS.

        1. Visits at new PPP sites by current PPP providers in underserved geographic areas in these SPAs and/or visits at sites operated by current PPP providers but not currently funded in their contract.

        2. Additional visits at existing PPP sites in these SPAs.

        3. Additional visits for clinics in SPAs 2, 4, and 5, which provide at least 50 percent of their PPP visits to patients residing in SPAs 1, 3, 6, 7, and 8.

DHS and CEO propose the following:

a. To receive a portion of the $38.5 million for recommendations 2 and 3, performance metrics must be developed, best practices encouraged and clinics must show how new visits can be sustained after 3 years, when County funds are depleted.

    This will allow DHS to monitor the use of these funds in a way that can ensure accountability. DHS will work with its PPP providers to develop similar performance metrics and best practices to incorporate into all PPP provider contracts.

b. Projects may include a) new or expanded school-based health clinics that offer services to families and b) PPPs providing services at DHS directly operated sites.

    As indicated above, this language is intended to clarify that the DHS solicitation process will encourage proposals which seek to leverage other

resources in meeting the need for additional infrastructure capacity in these areas.

c. Recipients of funds must identify how County funds will leverage other funds.

Implementation of Recommendations

To implement the recommendations below, DHS and CEO propose that the $44.8 million be awarded through an expedited solicitation process which DHS is developing, in consultation with County Counsel. DHS will provide the Board, in regular reports beginning in March 2009, with information, including timelines, regarding the solicitation process, copies of the solicitation documents, and progress reports on selection of successful bids and awarding of funds to providers. Approval of funding agreements will be submitted for the Board for approval.

In addition, DHS will convene as needed meetings with the CCALAC leadership and its members to discuss issues related to implementation of these recommendations, including but not limited to actions that can be taken to maximize the use of funds available for proposals in underserved areas where the lack of existing infrastructure is particularly severe. DHS may also use these meetings to discuss issues related to the development of performance measures and future proposals for special projects, as well as other process issues.

For planning purposes only, DHS has projected the distribution of the $38.5 million in recommended funding by SPAs based on their relative percentages from the 2008 Allocation Formula. Attachment IV is a bar chart which reflects those planning projections. In developing the distribution, DHS projected funding at a level which maintained SPA 8 at its current relative percentage level based on the 2008 Allocation Formula percentage. DHS then projected the available funds for SPAs 1, 3, 6 and 7 based on the amount which would increase their percent of funding to 71.5 percent of their 2008 Allocation Formula percentages. This methodology is similar to one included in the CCALAC recommendations. For SPAs 2, 4 and 5, DHS allocated the $1.0 million a year based on their relative percentages from the 2008 Allocation Formula. These planning estimates will change if additional funds are provided to qualifying SPA 2 projects to maintain SPA 2 at the 2008 Allocation Formula percentage. Actual funding percentages will depend on final approval of proposals submitted and qualifying for use of these funds.

DHS Report on Specialty Clinic Services

DHS has already undertaken a number of initiatives to improve access to, and manage demand for, specialty care services, which DHS believes will assist them in addressing issues related to the increase in primary care services proposed above.

In September 2007, DHS began countywide deployment of the Referral Processing System (RPS). RPS is a web-based system that allows DHS and PPP program providers to make electronic referrals to DHS referral centers for specialty care. DHS referral centers receive the electronic specialty care request and forward it to a clinician for clinical review. Approved requests are processed by the referral center where an appointment is scheduled and the patient is sent an RPS-generated appointment letter. After the patient is seen at the appointment the doctor's progress notes can be uploaded into the system where the original referring clinician can access them through the RPS site.

RPS has improved tracking and disposition of specialty care referrals, provides system wide information on the demand for specialty care, and improves the sharing of information between DHS and PPP providers and the return of the patient to their medical home. DHS plans to enhance RPS functionality by standardizing referral criteria across DHS facilities and specialty departments, imbedding standardized clinical prerequisite criteria into RPS, creating an upload of appointment data into RPS, providing users with expanded access to physician progress notes and other clinical information, and creating standard reports listing referral activity for users to access through RPS.

The DHS Healthy Way LA (HWLA) program includes a number of initiatives to manage the demand for specialty care and to improve access to care. HWLA provides health care coverage to low-income uninsured adult legal residents who receive care at DHS and PPP locations. Members are assigned to a medical home and receive expanded access to primary, preventive and specialty care services; urgent appointment access; 24/7 nurse advice line; member services; and care coordination services. The target population for HWLA includes individuals with chronic medical conditions such as hypertension, diabetes, congestive heart failure, asthma or chronic obstructive pulmonary disorder, or dyslipidemia.

The HWLA medical home provides members with primary care and preventive services and coordinates referrals to specialty care. Members with certain chronic medical conditions are referred to case management programs which emphasize disease management and providing care in the most appropriate venue. HWLA has supported the implementation of the ESS, for which the Workgroup has recommended $1.5 million in one-time funds.

HWLA has expanded specialty care services in both DHS and PPP locations. DHS has increased optometry, ophthalmology, and podiatry services in its non hospital-based ambulatory care network. Thirty-one PPP providers received HWLA funding to provide specialty care services including optometry, ophthalmology, podiatry, and cardiology.

In addition, the PPP Program agreements that went into effect on July 1, 2008 increased the number of PPP Program providers who received funding for specialty care in their base PPP agreement from two to six. Also in July 2008, DHS entered into agreements with 14 PPP providers in the MLK service area through the Strategic

Initiative Program which was implemented using SB 474 funding (South Los Angeles Medical Services Preservation Fund). Strategic Initiative Program providers had the option of using the funding for primary, specialty, or urgent care, either through direct service delivery or through infrastructure that leads to expanded capacity.

In September 2007 the Kaiser Permanente Community Benefit Program launched a specialty care grant initiative to fund 12-month planning grants to be followed by multi-year implementation grants. DHS is participating in five implementation projects funded in Los Angeles County. The five projects target different geographical areas. The purpose of the projects is to increase access and reduce demand for specialty care for the community's uninsured and underinsured populations. These projects are increasing the supply of specialty care, providing specialist training to primary care providers, and decreasing demand through better referral guidelines and improved communications between specialists and referring providers.

Attachments

PPP Recommendations Jan 2009

CCALAC RECOMMENDATIONS FOR USE OF ONE-TIME FUNDS FOR LA COUNTY'S PUBLIC PRIVATE PARTNERSHIP PROGRAM

On October 7th, 2008, the LA County Board of Supervisors instructed the Chief Executive Officer to reconvene the Public Private Partnership Allocation Workgroup to develop recommendations on the strategic use of:

- $4.8 million in infrastructure dollars in under-equity Service Planning Areas (SPAs), and
- $40 million to address PPP inequity in under equity SPAs and other underserved areas of the County.

Further, the Board moved that the Workgroup recommend strategies for improving coordination of care—including the creation of medical homes, especially for frequent users of emergency room services, and strategies on how the use of these funds can be implemented, monitored, and overseen to ensure accountability and encourage best practices.

CCALAC represents the non-profit community and free clinics that operate primary care sites throughout LA county, including all 33 of the PPP Strategic Partners. The association strives to identify and address the collective needs of our members at the local, state and federal levels. To appropriately respond to the request of the Board of Supervisors, CCALAC worked with our members to develop recommendations on the response to the Superviors' motion.

Through the Association's Compensated Care and Public Policy Advisory Group and the membership meetings, CCALAC engaged our members in a dialogue regarding these recommendations. It was a challenge for members to address past funding inequities while being strategic about new challenges, in particular given the limited amount of funding available. **The following recommendations reflect a majority consensus of CCALAC's members regarding how the PPP funding and Supervisors' motion should be addressed**:

BOARD MOTION: SET ASIDE $4.8 MILLION TO ESTABLISH NEW CLINIC SITES IN UNDER-EQUITY SPAS, TO BE SPENT BEFORE THE REMAINING FUNDS ARE DISTRIBUTED.

PPP clinics have leveraged federal and private funds to expand sites and services for the underserved. Over the past five years, community clinic organizations across LA county have made major strides in adding additional sites and services: clinics within CCALAC's membership have added 27 clinic sites, increased the number of sites with Federally Qualified Health Center designations by 23, and those with Look-Alike designation by 11. Five organizations are new Section 330 FQHC grantees with applications pending for 11 sites.

Clinics have made significant expansions countywide in the past five years, and have plans underway to create additional sites:

CCALAC Members Current and Planned Sites[1]

SPA	Sites June 2008	Increase Since 2003	Planned Sites
1	**3**	**-**	**1**
2	26	7	3
3	**8**	**2**	**3**
4	40	7	3
5	6	-	1
6	**14**	**1**	**3**
7	**16**	**4**	**1**
8	**16**	**6**	**4**

While the number of access points has increased in the past five years, the amount of PPP funding for services has not increased to fill the capacity created with these new access points. **With no significant increase in their organizational maximum contract obligations, clinics simply split their PPP funding between old and new sites in order to create access for the PPP program at these new locations.**

CCALAC RECOMMENDS THAT THE COUNTY:

Follow the input from PPPs given in prior PPP Allocation Methodology Workgroup convenings:

- ***Allow for expanded capacity at current sites because:***
  - ***Current sites are already in high-need areas and need investments in order to improve and increase services.***
  - ***Expansions at current sites are less costly than creating new sites, and usually allow for speedier increases in access to services.***
- ***Make funding flexible to allow providers to best suit expansions to their patient population and service area.***
- ***Invest in provider efficiencies and improved practices which improve the coordination of care as required by another portion of the motion. SB474 and the Cedillo Alarcon Community Care Investment Act provide examples.***
- ***Leverage funding for new sites, where possible.***

BOARD MOTION: SET ASIDE $40 MILLION IN ONE-TIME FUNDS TO ADDRESS PPP INEQUITY IN UNDER-EQUITY SPAS OVER A THREE-YEAR PERIOD, INCLUDING REPLICATING SUCCESSFUL MODELS AND LEVERAGING ADDITIONAL OUTSIDE FUNDING. ADDITIONALLY, CONSIDER AREAS OF THE COUNTY THAT ARE UNDERSERVED.

The PPP Allocation Methodology Workgroup developed a methodology to address the funding inequities between the Service Planning Areas. The methodology was agreed upon by the PPP

[1] CCALAC LA County 330 Expansion Planning Report June 2008. Under-Equity SPAs bolded/highlighted. Note: since June 2008, one planned site in SPA 3 has officially opened.

providers, LADHS and the County CEO in the recommendations presented to the Board in April of 2008.

The PPP allocation methodology estimates the "unmet need" among low-income uninsured in the county, which is Total Need – Supply. The final result is a percentage of total countywide need, which is then compared to the SPA's share of county PPP funding. For example, SPA 3, according to the Methodology, bears 20.36% of the share of the county's unmet need, yet receives only 13.35% of the funding allocation.

The SPA allocation methodology provides a beginning measure by which to address inequities in relative funding across large geographic areas. This does not assume that the total level of funding countywide, or in any Service Planning Area, is adequate to address the unmet need of that area. Indeed, certain pockets at the sub-SPA level may have a high level of unmet need and little PPP resource investment. The Workgroup must also provide recommendations on addressing these pockets of poverty and need. One suggestion from the Board of Supervisors was to consider the federal Health Resources and Services Administration Health Professional Shortage Area (HPSA) designation as an indicator of need. HPSAs may be designated as having a shortage of primary medical care, dental or mental health providers. They may be urban or rural areas (Geographic Area HPSA), population groups (Population Group HPSA) or medical or other public facilities (Facility HPSA). All Federally Qualified Health Centers (FQHCs) including FQHC Look-Alikes receive automatic facility HPSA status. **Each FQHC is HPSA-designated as an entity, encompassing all service locations included in the approved scope of work. As of October 2008, Congress passed legislation to make Automatic Facility HPSAs *permanent designations*.** This designation does not expire.

Several geographic areas, such as Medical Service Study Areas (MSSAs), census tracts and zip codes, are sub-SPA areas at which disproportionate need can be assessed. Factors that may indicate a sub-SPA area is underserved include poverty and coverage indicators and clinic-level data. The following recommendations do not include a methodology for identifying sub-SPA pockets of need, but do offer considerations for this funding.

CCALAC RECOMMENDS THAT THE COUNTY:

- ***Address Service Planning Area inequities by allocating 75% of the one-time funds to SPAs 1, 3, 6, 7, and 8 over three years, allocating $10 million each year. Address disproportionate need at the Sub-SPA level by allocating 25% of the one-time funds ($10 million) to SPAs 2, 4 and 5 over 3 years, allocating $3.33 million each year.***
- ***Select a funding mechanism that will get resources allocated and distributed <u>within 90 days</u> of Board motion to providers.***
- ***Allow for sustainable capacity increases in areas receiving funding, and for ramp-up of services over the three year period.***
- ***Ensure that the methodology for distributing this funding not be used for future allocations beyond this three year period. The funding methodology and the dialogue for its creation should inform future discussions on how best to build a system of care that meaningfully captures the needs of the entire county. While the investment is not enough to bring the system to full equity, this one-time funding***

should serve to help stabilize a system out of balance, and set it towards improved sustainability.

- ***Plan for sustainability in the out-years, beyond the three-year time frame of this funding.***
- ***SERVICE PLANNING AREA INEQUITIES ($30 million over 3 years):***[2]
  Address Service Planning Area inequities by allocating 75% of the one-time funds to SPAs 1, 3, 6, 7, and 8 over three years, allocating $10 million each year utilizing the SPA Allocation Methodology. At the current reimbursement of $94 per visit, this investment will allow for the expansion of 319,148 visits in these SPAs.
  - ***The distribution of this funding should capture the degree of unmet need in each SPA and bring each SPA toward their equitable allocation.***
  - ***By targeting 75% of the funds over three years, 65.11% of the shortfall in each of the under equity SPAs can be addressed. See the attachment "SPA Allocation Scenarios" for a discussion of CCALAC's recommended allocation scenario.***
- ***SUB-SPA INEQUITIES ($10 million over 3 years):***
  Address disproportionate need at the Sub-SPA level by allocating 25% of the one-time funds ($10 million) to SPAs 2, 4 and 5 over 3 years, allocating $3.33 million each year. At the current reimbursement of $94 per visit, this investment will allow for the expansion of 106,383 visits in these sub-SPA areas.
  - ***Geographic area: Medical Service Study Areas (MSSAs), census tracts and zip codes are sub-SPA areas at which disproportionate need can be assessed.***
  - ***Factors of need: start with poverty indicators, and allow providers flexibility to make the case with clinic-level data.***
  - ***Allow for consideration of how providers serve these areas. Also consider language and cultural barriers to access, such as for the homeless and GLBTQ populations.***
  - ***Encourage collaboration among providers serving high need areas.***
  - ***RFAs such as the SB 474 South Los Angeles Strategic Initiative RFA provide an example of how the county can tie expansions in services to a particular area of need.***[3] ***In the example of SB474, the clinics' workplans involve the tracking of patients served by zip codes of residence in order to demonstrate the increase in services for that particular patient population. In addition, clinics were encouraged to submit collaborative proposals.***

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[2] ***Note:*** any funding increase to the under-equity SPAs has an impact on the relative equity of the at-equity SPAs. For example, the investment of $30 million into the under-equity SPAs pushes the SPA 2's share of total funding from 17.29% to 14.52%, two points below its equity allocation of 16.78%. Because the relative level of current funding may cause a SPA to be only slightly over or under the equity threshold, it is important to note how total funding impacts equity across the County.

[3] SB 474 RFA is provided as an attachment to this document.

BOARD MOTION: RECOMMEND STRATEGIES FOR IMPROVING COORDINATION OF CARE—INCLUDING THE CREATION OF MEDICAL HOMES, ESPECIALLY FOR FREQUENT USERS OF THE EMERGENCY ROOM SERVICES.

Care coordination is the hallmark of community clinics and health centers, and a central tenet of the PPP program. As documented separately with the Allocation Workgroup, the PPPs currently engage in a wide number of activities to improve care coordination:

- Technology improvements reduce duplication of services, improve access to clinical data, and improve coordination across providers.
- Chronic disease management activities improve the collection and tracking of patient health indicators to better manage chronic diseases such as asthma, hypertension and diabetes.
- Specialty care coordination facilitate better screening and referrals, and improved access to these services.
- Frequent user programs decrease inappropriate utilization of the ER through the creation of medical homes, and improve coordination of services between clinics and hospitals.

PPP providers combine resources to improve the health outcomes of the underserved. The PPP Program serves a high number of adults with chronic disease, who might otherwise use the emergency room for care. Adults with asthma, diabetes, hypertension or a lipid/cholesterol problem account for 40% of all PPP users.[4] PPP users with chronic diseases made an average of 4.6 visits per year compared with an average of 2.1 visits for PPP users without these chronic diseases.[5] This finding points to the importance of the PPP Program as an effective system for preventing morbidity and mortality, including the overuse of emergency rooms and hospitals.

CCALAC RECOMMENDS THAT THE COUNTY:

- ***Support current efforts at coordination of care utilizing some portion of the $4.8 million. Do not start new initiatives that would duplicate efforts already underway.***
- ***As part of the $4.8 million in infrastructure funding, allow providers to use their funds for efficiencies and improved practices which improve the coordination of care. SB474 and The Cedillo Alarcon Community Care Investment Act provide examples of such investments.***

BOARD MOTION: RECOMMEND STRATEGIES ON HOW THE USE OF THESE FUNDS CAN BE IMPLEMENTED, MONITORED, AND OVERSEEN TO ENSURE ACCOUNTABILITY AND ENCOURAGE BEST PRACTICES.

The members of CCALAC believe that the intent of the Public Private Partnership (PPP) was to begin to build a system of primary care for the indigent in Los Angeles County. While the program has been very successful the system remains fragmented. We believe strongly that an oversight body should be established that expands on the partnership between the County and the community clinics to include other private stakeholders in the planning, development, monitoring and oversight of the resources and programs that are needed to establish a coordinated system of primary care for the low income members of our community.

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[4] Darryl Leong, MD. *The Power of Partnership: Solutions Created and Lessons Learned by the Public Private Partnership*, Prepared for CCALAC, May 2005.

[5] Ibid.

This new body would be comprised of representatives of the Board of Supervisors, appropriate County departments, the private sector including the PPPs, and other key non-county organizations. The members would be appointed by the Board of Supervisors and would assume governance and administrative responsibility for developing and implementing a plan for community centered primary care service delivery that maximizes current resources while identifying short and long term strategies for attracting new revenues.

There are far too many residents of Los Angeles relying on us to address their need for access to quality, coordinated, culturally appropriate health care. Without an adequate primary health care system that strives to keep people healthy and out of the emergency rooms, the entire system will collapse.

ADDITIONAL CONSIDERATIONS / FUTURE CONCERNS

Each Service Planning Area in LA County has areas of high need for health care services, and there is not sufficient funding in any area of the County to adequately meet this need. The investment that the Supervisors' have made will make strides in stabilizing the safety net of community clinics over the next three years.

In addition to the above recommendations related to the motion and the 3 year timeframe of this funding, CCALAC also offers the following recommendations for consideration beyond this current dialogue.

CCALAC RECOMMENDS THAT THE COUNTY:

- ***Enhance the reimbursement rate to enable the PPPs to keep up with the increasing costs of delivering health care services. With the downturn in the economy, PPPs will find it increasingly difficult to raise funds to offset the cost of caring for PPP patients.***
- ***Create a plan for fully stabilizing the PPP program beyond the three-year timeframe of this funding. This will allow for a longer range vision of health care in LA County.***

ATTACHMENT:
SPA ALLOCATION SCENARIOS

The SPA Allocation Methodology estimates the "unmet need" among low-income uninsured in the county across Service Planning Areas: Unmet Need = Total Need – Supply. The need is the number of residents by SPA who are uninsured and below 200% FPL, multiplied by expected primary care utilization rates (age-adjusted). The supply is calculated by the number of visits by SPA made by residents who are uninsured and below 200% FPL at DHS facilities, Licensed Clinics, Hospitals and Health Centers). The final result is a percentage of total countywide need, which is then compared to the SPA's share of county PPP funding. For example, SPA 3, according to the Methodology, bears 20.36% of the share of the county's unmet need, yet receives only 13.35% of the funding allocation.

The following tables show two scenarios for annually allocating funds across the "under-equity" SPAs. To best work toward equity in the proportional allocation of PPP funds, **CCALAC recommends that the county utilize the second scenario.**

Scenario 1: Distributing $40 million strictly according to percentage of unmet need.
We take a strict interpretation of the methodology and simply divide the $40 million between the under-equity SPAs according to their calculated unmet need:

- We divide $40 million by each SPA's percentage calculated unmet need (column B), and further divide this by three to find each SPA's share of the $40 million (column G).
- Next we add this amount to the FY 2008-08 allocation for that SPA (column E), to determine the SPA's new total allocation (column H).

Simply dividing the funds between under-equity SPAs in this manner will cost $9,686,667 per year. The impact on equity to each SPA will vary depending on its current share of countywide PPP funding (column C), and the SPA's shortfall to its equity allocation (column F). For example, this approach would provide SPA 8, which bears 13.21% of the unmet need, with $1,761,333, $651,653 more than its shortfall from equity of $1,109,680. Under this scenario, the total percentage shortfall from equity is reduced from 30.32% to 21.06%, a 9.26 point drop.

Scenario 2: Distributing $40 million equitably across percentage shortfall
In the second scenario we attempt to bring each SPA up an equal distance toward its equity allocation using a similar level of funding required in the first scenario, $10 million per year:

- We divide $10 million by the total shortfall to equity distribution of $15,359,530.61 (column F). This shows that a $10 million investment will bring the countywide equity shortfall 65.11% closer to the equity allocation.
- We then calculate 65.11% of the shortfall to equity for each SPA, to determine the amount required to each SPA an equal distance toward its equity distribution (column G).
- Next we add this amount to the FY 2008-09 allocation for that SPA (column E), to determine the SPA's new total allocation (column H).

Unlike in the first scenario, under this methodology the impact on equity to each SPA is controlled so that it takes into account the funding the SPA currently receives and its shortfall from equity. The impact to the countywide percentage shortfall from equity under this scenario is

a 9.49 point drop in the percent shortfall, from 30.32% to 20.83%. Compared to the first allocation scenario, this option offers a .23 point greater impact on equity.

NOTE: any funding increase to the under-equity SPAs has an impact on the relative equity of the at-equity SPAs. For example, the investment of $30 million into the under-equity SPAs pushes the SPA 2's share of total funding from 17.29% to 14.52%, two points below its equity allocation of 16.78%. Because the relative level of current funding may cause a SPA to be only slightly over or under the equity threshold, it is important to note how total funding impacts equity across the county.

Allocation Scenario #1: Distributing $40 million to Under-Equity SPAs strictly according to umet need[6]

A	B	C	D	E	F	G	H	I	K
SPA	2008 Allocation Formula (Unmet Need)	% Allocation 2008/09	% Point Shortfall	FY2008/09 Allocation	Shortfall from Equity Distribution of FY2008/09 Allocation	Allocation of $40 million funds by unmet need	New Total Allocation	% Total Allocation FY08/09 With Additional Allocation	Final % Point Shortfall with $10m
1	*2.49%*	0.82%	1.67	$415,674	$845,664.26	332,000	*$747,674.00*	1.24%	1.25
2	*16.78%*	17.29%		$8,760,792			$8,760,792	14.52%	2.26
3	*20.36%*	13.35%	7.01	$6,762,854	$3,550,739.16	2,714,667	*$9,477,520.67*	15.71%	4.65
4	*10.98%*	32.26%		$16,343,297			$16,343,297	27.08%	-16.1
5	*-0.40%*	8.11%		$4,109,900			$4,109,900	6.81%	-7.21
6	*18.40%*	8.41%	9.99	$4,259,639	$5,061,093.52	2,453,333.33	*$6,712,972.33*	11.12%	7.28
7	*18.19%*	8.73%	9.46	$4,422,001	$4,792,353.59	2,425,333	*$6,847,334.00*	11.35%	6.84
8	*13.21%*	11.02%	2.19	$5,581,998	$1,109,680.08	1,761,333.33	*$7,343,331.33*	12.17%	1.04
Total	*100%*	100.00%	30.32	$50,656,155	$15,359,530.61	9,686,667	$60,342,821.33	*100%*	21.06

[6] **NOTES:**

- **Column F** shows the shortfall each SPA had from their equitable distribution of FY2008-09 funding according to unmet need.
- **Column G** specifies the allocation each SPA would receive under this scenario.
- **Column I** shows the new percentage of the total funding the SPA would received with the additional allocation.
- **Column D** shows the percent point shortfall to each SPA's equity distribution prior to distributing the new funding.
- **Column K** shows the new percent point shortfall to each SPA's equity distribution after distributing the new funding.

Scenario #2: Distributing $30 million ($10 milion) per year to Under-Equity SPAs equitably across percentage shortfall[7]

A	B	C	D	E	F	G	H	I	J	K
SPA	2008 Allocation Formula (Unmet Need)	% Allocation 2008/09	% Point Shortfall	FY2008/09 Allocation	Shortfall from Equity Distribution of FY2008/09 Allocation	Allocation of $10m	Total Allocation FY08/09 With $10m	% Total Allocation FY08/09 With $10m	% Shortfall Made Up With $10m	Final % Point Shortfall with $10m
1	*2.49%*	0.82%	1.67	$415,674	$845,664.26	$550,579.49	*$966,253.49*	1.59%	*65.11%*	0.90
2	*16.78%*	17.29%		$8,760,792			*$8,760,792.00*	14.44%		2.26
3	*20.36%*	13.35%	7.01	$6,762,854	$3,550,739.16	$2,311,749.79	*$9,074,603.79*	14.96%	*65.11%*	5.40
4	*10.98%*	32.26%		$16,343,297			*$16,343,297.00*	26.94%		-16.1
5	*-0.40%*	8.11%		$4,109,900			*$4,109,900.00*	6.78%		-7.21
6	*18.40%*	8O.41%	9.99	$4,259,639	$5,061,093.52	$3,295,083.46	*$7,554,722.46*	12.45%	*65.11%*	5.95
7	*18.19%*	8.73%	9.46	$4,422,001	$4,792,353.59	$3,120,117.22	*$7,542,118.22*	12.43%	*65.11%*	5.76
8	*13.21%*	11.02%	2.19	$5,581,998	$1,109,680.08	$722,470.04	*$6,304,468.04*	10.39%	*65.11%*	2.82
Total	*100%*	100.00%	30.32	$50,656,155	$15,359,530.61	$10,000,000.00	$60,656,155.00	*100%*	*65.11%*	20.83

[7] **NOTES:**

- **Column F** shows the shortfall each SPA had from their equitable distribution of FY2008-09 funding according to unmet need.
- **Column G** specifies the allocation each SPA would receive under this scenario.
- **Column I** shows the new percentage of the total funding the SPA would received with the additional allocation.
- **Column D** shows the percent point shortfall to each SPA's equity distribution prior to distributing the new funding.
- **Column K** shows the final percent point shortfall to each SPA's equity distribution after distributing the new funding.

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Preliminary Feedback and Executive Summary

KEY INFORMANT INTERVIEWS

DRAFT – FOR DISCUSSION ONLY – December 17, 2008

Introduction

The Public-Private Partnership Program [PPP] Workgroup was charged with developing a set of recommendations to the L.A. County Board of Supervisors on how to most effectively allocate $44.8 million in new one-time primary care funding pursuant to a unanimously approved Board motion on October 7, 2008.

The California Endowment independently contracted with Bobbie Wunsch, Partner with Pacific Health Consulting Group, to interview 18 state and nationally recognized primary care experts and other key informants to gather their thoughts on how these funds could be most effectively spent. The preliminary results are summarized below. A full version of the report will be completed and available in early January 2009.

The experts both provided overall guidance concerning the broader economic and political environment within which the work group must develop its recommendations and suggested specific, concrete ways to use the funding. Most of the individuals interviewed were not familiar with the details of the PPP program and therefore offered broader feedback. These specific ideas largely fell within three categories: (1) investing in technology and infrastructure; (2) implementing new models of care delivery; and (3) realigning funding incentives. We have included a list of those interviewed to date as well as the questions that were asked (Attachments A and B).

General Guidance

Respondents encouraged the County to consider decisions about allocating the one-time funds in the broader context of potential efforts towards establishing a national health coverage program led by President-elect Obama. Safety net providers must be ready for reform because the most viable national reform plans under discussion rely heavily on the expansion of Medicaid, Medicare, SCHIP and other public programs. A number of respondents suggested allocating the one-time funding in a way that moves the PPP clinic system towards embracing models that will likely be incorporated in any reform at the federal level (e.g. pay for performance, prevention, electronic transfer of information, medical homes, better alignment of funding incentives).

In counterpoint to the optimism around national health reform, respondents also cited the severe economic downturn as a barrier to implementing some potential system improvements. For example, implementing some of the suggested technology and delivery systems changes will be challenging, as many clinics will likely be coping with a spike in demand for services from uninsured residents which may constrain their ability to adopt new delivery models and technology.

Many respondents pointed out that demand for services at community clinics in aggregate will always exceed supply. Using the one-time funding as an investment in improving efficiency will allow clinics to maximize the services they can provide, given the uncertain and fluctuating funding streams that they rely on for ongoing operating support. Respondents also cautioned that substantial investment in training and workforce development will be necessary to incorporate any of the strategies for system improvement suggested during the interviews.

Respondents also cited the importance of evaluating the outcomes associated with the investment of the $44.8 million. The funding should be contingent on achievement of specific, measurable and realistic goals and incentives should be structured into the program to encourage PPP clinics to meet their goals.

Some respondents who are familiar with the current PPP network cited challenges in the organization and management of the PPP program. Recently, key staff vacancies at DHS have left the program without steady leadership and a clearly defined direction. To address these issues, respondents suggested improvements in strategic planning and oversight of the PPP program at the county government level, and more collaboration and resource sharing among PPP clinics.

Specific Suggestions

1) Invest in technology and capital infrastructure:

Investment in technology infrastructure was the most common issue raised by the respondents. For those familiar with the LA County PPP program, there was a sense that the LA County primary care system has lagged behind other regions in the implementation of technology. In particular, a clear opportunity exists for expanding the electronic transfer of information through a variety of techniques. Other California counties have experienced significant success on this front.

For example, Alameda County has made significant advances with its One-e-App technology, which is still in limited use in L.A. County. In addition, Orange County has made progress in the implementation of a web-based data repository that can be shared by providers across its health system through its MSI program for indigent care with ClinicConnect for all participating clinic providers and EConnect for its emergency

room providers. In San Francisco providers have had success with specialty care e-referrals. These practices are in limited use in L.A. County.

A common suggestion around technology was the implementation of disease registries. Respondents acknowledged the challenges of moving towards a full-fledged electronic health records (EHR) system, but agreed that this should be the long-term goal. Comprehensive disease registries would be the logical first step in this process. Technological Innovations such as telemedicine were also mentioned as ways to improve efficiency. Many respondents stressed that technological innovations must be directed at sharing information across the entire PPP program, in order to achieve results in improving quality of care.

Should the funding go to technology improvements, there was a consensus among respondents that it be contingent on meeting certain technological benchmarks that have been proven to increase clinic effectiveness and quality of care. Given that the funding will be allocated over three years, incentives could be built in that require the implementation of disease registries and establishment of a timeline for other technological advances that help clinics make progress towards implementing EHRs. The funding could be staggered over the three years with distribution contingent on making progress towards EHR implementation.

Aside from technology, respondents also identified a need for more traditional "bricks and mortar" investments in infrastructure. Some suggested using the PPP funding to create incentives to increase capacity in underserved areas. For example loans could be set up to create new clinic sites, which would be forgiven if the clinic succeeded according to outcome measures attached to the funding. Other respondents suggested using the funding to expand existing clinics in high-need areas to improve capacity. However, whether the funding is used for technology or traditional bricks and mortar infrastructure, several of the experts cautioned that $4.8 million would provide limited impact across such a large system and that a larger proportion of the funds should be considered for infrastructure.

2) Modernize clinics by implementing new models of care delivery:

Many respondents suggested using the funding to improve coordination of care by PPP clinics, by implementing newer, more effective models of patient care delivery within clinics and across the safety net provider system. The high rate of chronic disease in the patient population served by clinics in the PPP program necessitates the implementation of innovative models for chronic disease management by providers. The most common practices cited included:

- Implementing chronic disease management programs and disease registries:
  - Including population management, protocol based regulation of medication, attention to treatment guidelines, self-management support and intensive follow-up.

- Care coordination combined with regular on-going care from the same provider:
  - For those patients who treat the clinic as a medical home, a team of providers assigned to a patient could include a primary care physician or nurse practitioner, nurse or medical assistant, nutritionist, health promotora and/or social worker.

- Integrating behavioral health services into primary care settings:
  - Having mental health providers available at clinics to work with primary care providers to address the physical and mental needs of a patient.

- Easier access:
  - Offering same day appointments and expansion of evening and weekend hours to meet needs to patients as well as implementation of group visits and nurse advisors or nurse advice lines.

In addition, some respondents also cited the following best practices that PPP clinics should consider replicating:

- Panel management programs
  - Allows the systematic review of an entire population of patients with the same chronic disease. Panel management attempts to address chronic care needs outside of a face-to-face office visit. Many of the tasks can be performed by a Panel Management Assistant which frees up time for physicians to address more urgent patient needs.

- Physician extenders
  - Shifting more responsibility for patient care to nurse practitioners and physician assistants, freeing up time for primary care providers to see patients with more urgent conditions.

Although many of these practices are currently being implemented within participating PPP clinics, respondents felt that this new funding could help to standardize and institutionalize these practices on a system-wide scale across the PPP program. Again respondents suggested that incentives be established to encourage the implementation of these best practices and suggested that the PPP program look at how managed care plans have incentivized these practices.

3) Realign payment incentives, leverage funding to help clinics stay viable in the future:

Many respondents cautioned against using this one-time funding for direct services to patients out of concern that such funding would create an expectation of ongoing care among the new patients served, when funding after the three year period is uncertain. This concern was heightened given the significant budget deficits facing state and local governments. Respondents stressed the importance of identifying opportunities to leverage these one-time funds to improve sustainability of the PPP clinics. For example, respondents suggested that the county could leverage public funds with existing philanthropic efforts to improve local primary care. Leveraging opportunities cited in interviews included:

- Building Clinic Capacity for Quality (BCCQ): A learning collaborative to support the implementation of quality improvement initiatives that are supported by health information technology.
    - Funded by: LA Care Health Plan, Blue Shield Foundation/Kaiser, UniHealth Foundation

- Capital improvement project loan fund for capital expansions for LA County clinics: The funding will support technical assistance for the planning of infrastructure expansion projects as well as provide loans with favorable terms.
    - Funded by: California Community Foundation

- Tools for Quality: Statewide initiative providing funding and training for implementation of chronic disease management systems in community clinics. The first patient population of focus is diabetes.
    - Funded by: Tides Foundation, The California Endowment, California Health Care Foundation, Blue Shield of California Foundation, Kaiser Permanente

- Accelerating Quality Improvement Through Collaboration (AQIC): Statewide collaborative quality improvement project focused on coordination of quality improvement measures and implementation strategies.
    - Funded by: The California Health Care Foundation

- Specialty care planning grants for Los Angeles County: Each Service Provider Area (SPA) was awarded $300,000 in planning grants.
    - Funded by: Kaiser Permanente

Respondents also cited the challenges of the current per visit fixed fee reimbursement model for clinic services that does not encourage providers to adopt practice innovations such as panel management, case management and integrated care. Often the respondents suggested adoption of managed care reimbursement techniques for those chronically ill patients that use a clinic as a medical home (per-member-per-

month, per-case, or per-user payment structure). This structure should also be accompanied by pay for performance incentives; a payment structure that rewards health care providers for meeting certain performance measures for quality and efficiency.

Some respondents suggested that PPP clinics be expected to leverage these new county funds with other matching funding to expand the potential of the funding and not to supplant other funding sources. The experts also encourage a continued focus on expanding FQHC and FQHC look-alike status among clinics in the PPP program in order to maximize federal and state reimbursement.

Methodology

The initial planning of the project focused on identifying the leading primary care experts locally and nationally. The interviewees were selected with the goal of capturing a variety of expertise within the field of primary care. The selection of the questions sought to strike a balance of providing opportunities for respondents to provide general thoughts and comments while also containing specific questions that attempted to inform the guidelines outlined in the Board motion. The members of the workgroup provided suggestions on appropriate individuals to be interviewed as well as feedback on the list of questions. Both the interviewee list and the list of questions are attached (Attachment A and B).

The interviews were conducted over the course of three weeks beginning in mid November. We were able to complete interviews with 18 of the 19 interviewees initially identified. Each interview lasted approximately one hour and they were recorded to ensure that their comments were captured accurately. To encourage open and honest feedback, no specific recommendations or comments included in the report have been attributed to the interview subjects. Each interview was summarized and then analyzed to draw out the major recommendations from respondents which have been compiled in the preceding executive summary.

Respondents also referenced several reports on successful implementation of technology infrastructure and care delivery improvement models that are listed in the attached bibliography (Attachment C).

Attachment A

Interviews conducted by Bobbie Wunsch, Pacific Health Consulting Group, from November 13, 2008 through December 12, 2008.

First Name	Last Name	Title	Affiliation	Date
Dr. Thomas	Bodenheimer	Adjunct Professor	UCSF Dept. of Family and Community Medicine	11/24/2008
Allison	Coleman	Chief Executive Officer	Capital Link, Inc.	11/21/2008
Jonathan	Freedman	Chief Deputy	Department of Public Health, LAC	12/8/2008
Robert	Gates	Deputy Agency Director	Orange County Health Care Agency	12/9/2008
Laura	Hogan	Vice President of Program	The California Endowment	11/20/2008
Bridget	Hogan Cole	Program Director	Building Clinic Capacity for Quality	12/12/2008
Howard	Kahn	Chief Executive Officer	LA Care Health Plan	11/13/2008
Kathy	Ko[i]	Program Director	Tides Foundation-Community Clinics Initiative	11/20/2008
Ingrid	Lamirault	Chief Executive Officer	Alameda Alliance for Health	11/14/2008
Dr. Sharon	Levine	Associate Executive Director	The Permanente Medical Group, Inc.	12/8/2008
Karen	Linkins	Consultant	Evaluator of the Frequent Users of Health Initiative	11/25/2008
Lisa	Mangiente[ii]	Consultant	Alameda Net	11/25/2008
Barbara	Mauer	Managing Consultant	MCPP Consulting	11/25/2008
Ed	O'Neill	Director and Professor	UCSF Center for the Health Professions	11/21/2008
Kathy	Reynolds	Chief Executive Officer	Washtenaw Community Health Organization	12/9/2008
Melissa	Schoen[iii]	Senior Program Officer	California Healthcare Foundation	12/12/2008
Ralph	Silber	Executive Director	Alameda Health Consortium	12/9/2008
Tony	Skapinsky[iv]	Project Consultant	Capital Link, Inc.	11/21/2008
Dr. Mark	Smith	President and CEO	California Healthcare Foundation	12/12/2008
Jane	Stafford	Senior Program Officer	Tides Foundation-Community Clinics Initiative	11/20/2008
John	Wallace	Chief of Staff	LA Care Health Plan	11/21/2008
Tara	Westman	Director of Grants Program	Weingart Foundation	12/8/2008

[i] Participated with Jane Stafford, Senior Program Officer , Tides Foundation-Community Clinics Initiative
[ii] Participated with Karen Linkins, Consultant, Frequent Users Initiative Evaluator
[iii] Participated with Mark Smith, President and CEO, California Healthcare Foundation
[iv] Participated with Allison Coleman, Chief Executive Officer, Capital Link, Inc.

Attachment B

QUESTIONS FOR KEY INFORMANTS

1. Based on your knowledge of the PPP Program, do you have ideas about how we can achieve and regularly document the outcomes of the program including patients seen as well as patients' health status?

2. Are there emerging and new models of delivering primary care and innovations that improve quality and create cost efficiency that we should consider supporting?

3. What can be learned from other funding allocation processes that you are familiar with or have experience with? Have any of those processes included a shift in allocation over time to account for changes in need? Are there experiences from other settings or other jurisdictions that we should research?

4. What policy initiatives are you aware of that hold promise for creating stable safety net care systems?

5. Are there other states or locales that we should look to for their innovation in this area? In funding allocation, in new models, in policy initiatives?

6. What have you seen as the missed opportunities in funding and strengthening outcomes in programs like LA's PPP/DHS program?

7. What barriers impede making needed changes? What needs to be done to overcome them?

8. How can the infrastructure of providers be strengthened in this process (especially in very underserved or under-equity areas)? What are the most effective ways of doing this with outside funding?

9. What training and infrastructure would need to be in place to implement and oversee your recommendations?

10. What recommendations do you think the working group should make to the Board of Supervisors regarding how it should spend the $44.8M dollars over three years. (Ask for at least three very specific and doable recommendations).

11. What policy changes must be implemented for long term financing of these recommendations? (Ask for any studies that have analyzed the patient outcomes/impacts of implementing these and other recommended changes).

12. Given the recent changes in the political and fiscal environment, what additional considerations should we make in forming these recommendations?

13. Are there any individuals within the County who should be tapped to work more closely w/PPPs to create clinical pathways for specialty care?

14. Do you have any specific recommendations for strengthening the infrastructure of PPP providers in South, East LA and Antelope Valley?

15. How can we ensure that the county best coordinates the need for additional specialty care services?

16. What recommendations do you have to improve the county's strategic planning, oversight and monitoring of the PPP program in the future?

    a. Should new oversight models be considered?
    b. Should additional community and stakeholder involvement be solicited? If so, in what form?
    c. Are there additional opportunities to collaborate among public and private providers?
    d. Are there strategies to encourage the use of evidence-based planning in the administration of the PPP program going forward?

Focused questions for Emergency Room Frequent Utilizer (FU) Expert:

1. How much time was needed to plan projects? Who needs to be at the table? What were the costs? What was the size of the planning grants?

2. Were successful projects the outgrowth of other collaborations in communities? What were those? Are there key factors that need to be in place?

3. What should LAC try to replicate?

4. What training/expertise is needed?

5. Who would you recommend as a program design consultant?

6. What were the elements that led to the successful cooperation of DMH/DHS?

7. Is there further analysis of LAC that could be shared about challenges faced? Are there LAC specific recommendations that are not included in the evaluation?

8. If LAC were to implement a regional pilot, what advice would you give?

Attachment C

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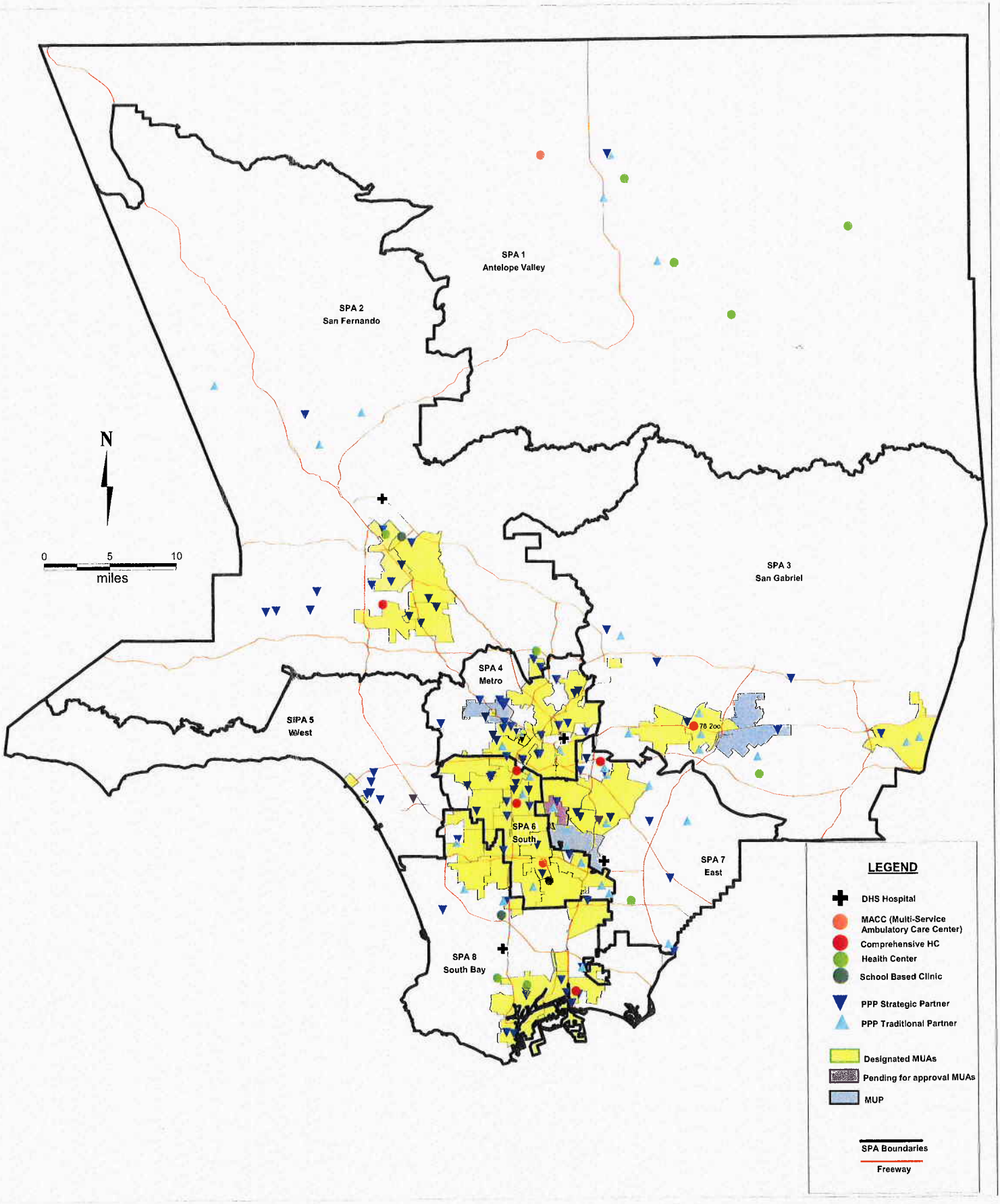
6. Mauer, Barbara. "Behavioral Health / Primary Care Integration and the Person-Centered Healthcare Home." MCPP Healthcare Consulting The National Council for Community Behavioral Healthcare: October 2, 2008 (Draft not yet distributed)

7. "Reducing Patient Wait Times." Primary Care Development Corporation: Excellent Healthcare in Every Neighborhood. http://www.pcdcny.org/programs/operations_success/patient_visit.html

Attachment III

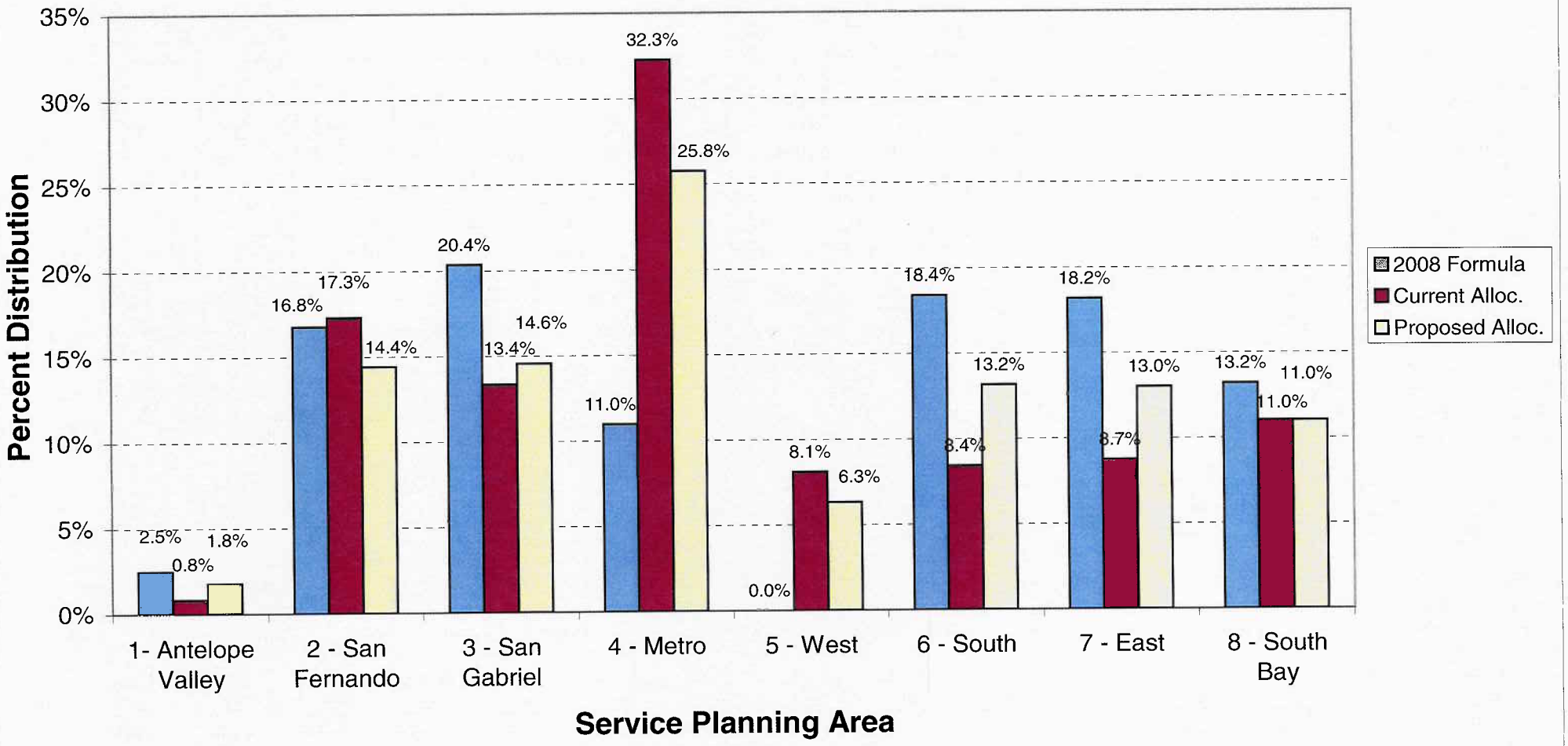
Los Angeles County
Designated and Pending Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs)



LAC DHS Office of Planning and Analysis
January 20, 2009

Current PPP Allocation (FY 08/09) Compared to 2008 Updated Needs Formula and Proposed Allocation (Current + New Funds)

DRAFT



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